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Running head: OLDER PEOPLE'S AGENCY IN REHABILITATION

Older People's Agency in Group Exercise Classes in Geriatric Inpatient Rehabilitation: Interaction
between Clients and Physiotherapists

Abstract

The aim of this paper is to explore how older people construct their interaction in group exercise classes in geriatric rehabilitation, and what is the scope of their agency? Discourse analysis was employed and data, consisting of 7 videotaped group based exercise sessions, were collected from 7 rehabilitation centers involving 52 older people (age 66 – 93 years) and 9 rehabilitation professionals. Four discourse categories were found. In 'taciturn exercising' older people remained verbally silent but physically active. In 'submissive disagreeing' older people were directly opposing the professionals' agenda with reluctant alignment to proposals. Where as in 'resilient endeavouring' older adults persisted on their stance, regardless of the disapproval of the professionals. In 'lay helping' older people initiated spontaneous encouragement, but also provided verbal and physical assistance for their peers. Older people's agency, whilst being likely to challenge institutional flow of activities, can be an integral part of the re-ablement process of rehabilitation.

Older People's Agency in Group Exercise Classes in Geriatric Inpatient Rehabilitation: Interaction between Clients and Physiotherapists

The purpose of geriatric rehabilitation interventions has been to maintain, achieve functional independence (Gill, 2005; Landefeld, Palmer, Kresevic, Fortinsky, & Kowal, 1995), and enable older people to remain community-dwelling (Hinkka, Karppi, Aaltonen, Ollonqvist, Grönlund, Salmelainen et al., 2006). The central focus in geriatric rehabilitation is older people's independence. However, the concept of independence in old age is rarely defined (Secker, Hill, Villeneuve, & Parkman, 2003) and most common usage refers to absence of disability or reliance of others in everyday activities (WHO, 2002). This individual autonomy is often equated to concept of agency (Wray, 2004), which can be defined as an ability to act otherwise, being able to extend range of causal powers (Giddens, 1984) (p.16).

Taking an active stance towards one's own health and independence in old age has been argued to be not only a matter of individual choice, but also a structural issue (Tulle & Mooney, 2002). This notion goes beyond physical contexts and environments to nexus of practises carried out by socially competent people in situated encounters (see (Goffman, 1963; Scollon, 2001). These multifaceted, contextual social systems can be seen as medium of practises, but simultaneously the agents are constructing these systems in their practices (1976; 1984). Thus, embodied agency can be studied in situated, practical encounters of social actors, where the agency is constructed in the ordinary flow of activities (Gubrium & Holstein, 1995). This pertains to doing things and its conventions, talking and communication of meaning in interaction, and contextual organisation of encounters (Giddens, 1984) (pp. 72-73).

Agency of Older People in Health Care Contexts

To date human agency, especially agency of older people has accrued relatively little research attention in health sciences. However, there has been research into older people's

autonomy during encounters in health care settings. In a hospital context older people's opportunities for participation in care decisions have been found to be limited through lack of negotiation, control of conversation agendas and failure to respond to cues (McCormack, 2001). In the context of adult day care, older people's agency and independence has been suggested to be limited due to underlying purposes of constraining choices (Moore, 2004). Such nursing practises that limit patient autonomy and the range of choices offered due to perceived need to protect patient's wellbeing are seen as paternalistic (McCormack, 2001). In ambulatory/outpatient services as well, older adults have encountered restrictive professional practises. Veteran elite runners with sport injuries, reported limited rehabilitative support from health care professionals, who recommended discontinuation of the sports activity (Tulle, 2007). In rehabilitation of older people in institutional settings opportunities for active participation and autonomy have been found limited due to rigid rules and procedures (Ballinger & Payne, 2002; Hart, Lymbery, & Gladman, 2005; Proot, Huijjer Abu-Saad, de Esch-Janssen, Crebolder, & ter Meulen, 2000). Emphasis placed on physical safety during rehabilitation has been found to discourage independent daily activity and reinforce passivity (Ballinger & Payne, 2002). Furthermore, much of activities during the rehabilitation have been found to adapt patients to the norms, expectations and values of the institution (Hart, Lymbery, & Gladman, 2005), which have been suggested to undermine the primary purpose of rehabilitation (Martin, Nancarrow, Parker, Phelps, & Regen, 2005).

For older people receiving physiotherapy in institutional setting opportunities for active participation in decision making and goal setting have been shown to be limited due to physiotherapists deciding the goals and treatments for patients (MacLeod, Thompson, Upton, Scott, & Chesson, 2002; Parry, 2004a; Wohlin Wottrich, Stenström, Engardt, Tham, & von Koch, 2004; Wressle, Öberg, & Henriksson, 1999). However, there seems to be alternative, although rare, physiotherapy encounters in institutional settings, where older people are allowed to elaborate their own views and participate into goal setting (Jorgensen, 2000; Parry, 2004a). Also clients'

interactional participation during the course of physiotherapy treatments has been found to increase upon learning to perform the exercises independently (Martin, 2004). Furthermore, it has been argued that infrequent discussions about problems and goals during physiotherapists' and clients' interaction in therapy encounters are due to the tactful management of physical incompetence and produced in collaborative interaction (Parry, 2004b).

In light of existing research findings, the issue of agency is particularly interesting in the context of geriatric rehabilitation aiming at enhancing older people autonomy and independence. In this study we draw upon Giddens (1984) for the duality of the social structures and human beings' agency in actively shaping their socio-cultural context (Giddens, 1976), thus human agency is defined as practical, situated actions whereby one chooses to intervene in order to produce another outcome that would have occurred without this intervention. In this study we will narrow the context into a institutional configuration of geriatric inpatient rehabilitation and in physiotherapy with its' group exercise classes. The focus is on physical and verbal interaction of participants. More specifically, we were interested to understand how older people construct their interaction during encounters with rehabilitation professionals in exercise sessions, and what the scope of their agency is?

Method

Sample and Data Collection

The data consisted of videotaped group exercise sessions of the intervention arm of the AGE study. In the AGE study, 741 frail community-dwelling older people with unstable health and a high risk of institutionalization were randomised either to a network-based inpatient rehabilitation intervention (n= 343) or to a control group (n=365) receiving normal social and health care services. The intervention was carried out by multidisciplinary teams at seven rehabilitation centres. The rehabilitation programme consisted of group and individual exercises, group discussions and health promotion activities in the areas of physical activity, self-care and nutrition. The focus was

on the active participation and autonomy of the older people. (Hinkka, Karppi, Aaltonen et al., 2006).

One exercise session was videotaped from each of the seven rehabilitation centres in 2002. The physiotherapists chose a group exercise session for recording. No criteria with reference to physical activity or construction of the sessions were applied. There were 52 older adults involved, their ages ranged from 66 to 93 years; seven were males. All of them were independent in mobility with or without assistive devices. Nine professionals were involved, all of whom were females. Seven of them were physiotherapists and in charge of the session, and in addition there were one occupational therapist and one exercise counsellor, who were involved in instructing clients. The amount of the professionals' work experience varied from one to over 20 years. Prior to recordings, the participants gave their informed consents and the approvals of the ethical committees of the Social Insurance Institution of Finland (SII) and the Turku University Hospital were obtained.

Analysis

The analysis is rooted in social constructivism (Berger & Luckmann, 1966; Burr, 2003; Gergen, 1997), assuming knowledge as socially negotiable and historically and culturally specific. The data was approached within an ethnomethodological frame of reference, taking any social occasion as specific, situated and skilful practise of its members whereby they construct the event understandable and accountable (Garfinkel, 1967). Qualitative analysis, applying discursive psychology (Edwards & Potter, 2001; Potter & Wetherell, 1987) was utilised, assuming that most social activity involves discourse that is situated, action-orientated and constructed. Furthermore, not only talk, but also gestures, actions and material objects are utilised to mediate meanings (Scollon, 2001). Thus, special attention was given to how specific actions, both verbal and physical, were constructed and at the same time constructing the scope of older people's agency geriatric rehabilitation.

The videotaped group exercise sessions were transcribed according to a simplified version of Jefferson conventions (Atkinson & Heritage, 1984) and non-verbal activity, such as body position, gaze, gesture, was annotated (Jordan & Henderson, 1995) (Table 1). The analysis of the group exercise data involved a close inspection of videos and writing of descriptive logs of each video. The data analysis sessions were carried out with co-authors. Systematic collection of interactional occurrences (e.g. clients initiations) in each video was carried out in order to scan through the whole data inclusively for the frequency of occurrences. This was performed to ensure the inclusions of all apparently typical and deviant cases. Then, a detailed analysis followed to identify patterns of consistency and variability, and functions of interaction. This involved noting how participants responded to each other's utterances, and what types of versions of social reality were constructed during the encounters. In the final analysis, clients' interaction during the exercise sessions were classified into different discourse categories.

Findings

In this study, there was a spectrum of older people's discourse categories during encounters with rehabilitation professionals during exercise sessions. Four discourse categories were identified during the analysis of the data. In 'taciturn exercising' the older people received the instructions and guidance without or with minimal verbal acknowledgement and participated by performing physical exercises. In 'submissive disagreeing' the older adults responded to the physiotherapist's instructions indicating trouble, emotions or disagreement, but submitted to the professional's judgment of the situation. In 'resilient endeavouring' the older people initiated and persevered on their stance. In 'lay helping' the older people initiated and persisted on providing support for their peers. The following extracts illustrate variation and typical features of each discourse category. All names have been changed, and each exercise session has been assigned a random number between 1 and 7.

Taciturn exercising

In group exercise sessions the primary objective was physical activity in variety of forms, thus the preferred structure of actions were physiotherapists instructing and clients exercising. At times physiotherapists (PTs) produced almost continuous flow of instructions of the exercises while older people remained verbally silent but physically active. However, this taciturn exercising was jointly constructed as illustrated in the following episode.

Extract 1: Session 2: Group sitting on benches in circulatory format performing warm-up exercises

- 1 PT: Good (5) And now let's run like a sprinter (3) GOOD! ((laughs)) A 100-metre sprint
- 2 (1) Good! (1) Use your opposite hand to tap (.) your knee (1) And every time you lift your
- 3 knee up and (5) and if you can lift your knee high enough then you can even tap your
- 4 elbow against your knee.

In the beginning of the above extract older people were sitting in a circle exercising. During this episode the older people performed activities silently attending to the physiotherapist, who provided instructions for the exercises with simultaneous model performance. The physiotherapist provided non-specific short responses 'Good!' (lines 1 and 2) to accomplish two tasks: to provide positive feedback and to indicate the end of current exercise sequence. There were several pauses in between the physiotherapist's utterances where older people could have taken verbal initiative, but chose to refrain from it. The physiotherapist did not solicit any verbal feedback from the clients, thus established preferred uninterrupted flow of exercise instruction and physical activity.

A common modification of this preferred flow of action was that some older people had difficulties following instructions and performing activities. Typically the physiotherapists noticed the difficulty and initiated further instructions providing verbal cuing and/or hands on assistance as illustrated in the following episode.

Extract 2: Session 3: Group standing by the exercise beam starting the warm-up exercises

- 1 PT: Good (.) then let's tread in one place (.) lift your feet (.) your knees properly () Good
- 2 keep going ((looks at Saima)) (.) Saima don't lift them too far up if you feel that

3 S: Right the thing was to.

4 PT: Yes (.) just small steps (.) enough to get the message to the sole of your feet that we're

5 now going to do this exercise ...

In the above extract, the physiotherapist introduced a new exercise and the clients started performing it without any verbal input. The physiotherapist observed client's performances and provided individualised guidance to one participant. Saima's response (line 3) indicated that she treated the guidance as newsworthy. She adjusted her performance without any interruptions and the physiotherapist proceeded with a flow of further instructions.

Submissive disagreeing

In group exercise sessions, episodes of dyadic interaction between a client and a physiotherapist allowed client's expressions of disagreement. These displays of misalignment were typically constructed by clients in a subtle way, but there were also episodes of direct opposing to physiotherapist's agenda with simultaneous, although reluctant, alignment to physiotherapists' proposals. At times physiotherapists conformed to clients' opposition and modified the task, but simultaneously maintained their status as professionals prescribing the activities.

Extract 3: Session 5: "Esteri" sitting on a chair resting from the previous exercises

1 PT: Then (2) Esteri (1) ((instructor looks at exercise points and then turns her eyes back to

2 Esteri)) Esteri is now going to have to ((laughs))

3 E: What? () you're not going to come and get me ()

4 PT: Come here (7) ((takes Esteri by the hand and leads her towards the exercise point, Esteri

5 follows behind her right shoulder)) let's do some line walking here but you don't have to

6 [get up here] ((points at the ramp))

7 E: [That's not] (.) I was thinking that if I don't get up that=

8 PT: =no you don't have to (.) yeah-

9 h. (.) But (.) let's put a cap on our head straightaway (1) ((instructor bends down to pick up a

- 10 frisbee from the ground and places it on Esteri's head)) come here (3) there you are (.)
- 11 now let's see whether you can keep your cap on ((laughs))
- 12 E: °No it won't stay there°.
- 13 PT: °Try° lift your head up a bit (.) let's see what happens when you just take a step like
- 14 you don't have to look down really you just need to put one foot in front of the other (1)
- 15 whoops ((laughs as the frisbee falls to the ground and picks it up))

In the above extract the physiotherapist approached “Esteri” calling her name and laughing (lines 1 and 2), prior to grasping her hands. Ester did not laugh and inquired the destination (line 3) objecting to participation in general. The physiotherapist bypassed this opposition and gave no options but to get up and going (line 4). Esteri remained taciturn and walked reluctantly staying behind the physiotherapist, who was leading her by the hand. The physiotherapist did not reveal the exercise site until (line 5) they had walked up to it, and instantly modified the exercise by omitting the obstacle prior to the beam walk. The client (line 6), resisted with overlapping talk the obstacle as well. The physiotherapist assured Esteri that she was in agreement with her. However, she indicated by using the word ‘but’ that this modification was coupled with using extra challenge during the beam walk, and added laughingly a Frisbee on Esteri's head (lines 8 through 10). Esteri was not laughing and uttered quietly her opinion about pending failure (line 11). The physiotherapist bypassed this negative account and proceeded with a long instruction (line 12 through 13). When the Frisbee fell off from Esteri's head, the physiotherapist uttered laughingly ‘whoops’ indicating unexpected but not serious incidence (line 13). The client did not laugh.

Resilient endeavouring

In group exercise sessions that were constructed in circuit training format, each client had their own exercise site with rotation between sites in order to try out each exercise, there were client

initiated episodes of exercise modifications or information solicitations. The initiations were generally treated as deviations from the standard flow of activities by the physiotherapists, but older adults persisted on their stance, as illustrated in the following extract 4.

Extract 4: Session 6: “Eila” initiated modification of resistance tube exercise by doubling the tube, due to having just broken the tube in prior turn.

- 1 E: () stronger?
- 2 PT: No don't put (.) it will hold (.) it was just (.) it's just that the old one it's been there so
- 3 long that that band has [it was time for it to snap].
- 4 E: [I'll do two ()] ((folds the band over))
- 5 PT: Yes you do that ((laughs)) (.) () except that then there's (.) yes well (.) Not too tight (.)
- 6 yes you (.) like that and then hold your back straight and just pull your elbows [back]
- 7 E: [I'm] too far
- 8 back () in the chair.

The client initiated (line 1) the modification to the resistance tube exercise by doubling the rubber tubing. The physiotherapist objected to the modification (line 2) by producing an account of the reason behind the tube getting broken in Eila's last exercise turn. This had not been due to Eila's performance, but in fact, something to be expected since the tube was worn out and thus, brittle. Eila demonstrated her determination to modify the exercise by overlapping talk (line 3) enforced by physically doubling the tube. The physiotherapist consented to the client's initiation (line 4) laughingly, which the client did not share. The physiotherapist proceeded to instruct Eila for proper posture during the exercise performance. Eila responded (lines 5 and 6) by producing an account where she reflected her understanding of the proper posture and positioning during the performance.

In the above extract the client persisted on her stance and successfully obtained the desired modifications with the physiotherapist's consent. However, in some episodes the physiotherapists did not accommodate clients' initiations but persisted in continuing the activity on their terms.

Clients' resilient endeavours were demonstrated in some episodes by reconstructing the situated meaning of the activity as illustrated in the following extract.

Extract 5: Session 5: "Aarre" in the obstacle course

- 1 PT: Let Aarre (.) no Pauli have a rest (.) have a rest and we'll have a go. ((looks at Aarre))
- 2 A: I think I'll go alone.
- 3 PT: Yes I'm sure you will yeah (3) Now this here this is a bit of a tougher spot. ((holds Aarre's hand))
- 4 A: That's nothing.
- 5 PT: ((laughs)) (3) Good.
- 6 A: There=
- 7 PT: =There (.) half of the job's done (.) [let's go back.]
- 8 A: [Right, back.]
- 9 PT: Right (4) you're doing great (8) there (.) wonderful.
- 10 A: Thank you very much. ((continues to hold the instructor's hand, turns towards the instructor and bows slightly towards her as a sign of thanks))
- 11 PT: Thank you ((laughs)) so sit down over there

In the above extract, the physiotherapist offered "Aarre" assistance in performing the obstacle course (line 1). Aarre's suggestion of an independent performance was denied by the physiotherapist's actions and utterance (line 3). While acknowledging that she was fully aware that he would have liked to go alone, the physiotherapist held his hand all the time he was walking through the obstacle course. Aarre did not respond verbally but continued the performance; thus allowed the physiotherapist to continue the turn. The physiotherapist did not explain the reason for providing physical assistance, but drew Aarre's attention to the fact that the obstacle course was demanding. Aarre proposed a divergent view of the exercise by stating that the exercise was not

difficult at all (line 4). The physiotherapist responded by laughter and a long pause, thus acknowledging the client's disinclination. Following the completion of the obstacle course, Aarre suddenly turned towards the physiotherapist, still hand in her hand, bowed and thanked her in the manner familiar in the end of a dance. The physiotherapist acknowledged this sudden response (line 11), by laughingly thanking in turn. She continued her turn, instructing the client to sit down, which served dual purpose. On the one hand allocating break after physical performance, but on the other hand indicating the closure of the episode. The client complied with the hint and returned to his seat.

Lay helping

Displays of peer support were observed in exercise classes of circulatory training mode. The physiotherapist was unable to provide instructions to everyone in the group at the same time. Further more, the older people were heterogeneous in their functional abilities. Some clients required constant verbal cuing, but some performed activities independently with confidence. Thus, this lack of the physiotherapists' resources to provide assistance and guidance, in combination with competence of some older adults with exercise performance, resulted in active lay helping. This lay helping occurred naturally and spontaneously and was always initiated by the older people. Lay helping consisted of encouraging, providing positive feedback, exhortation, but also providing verbal and physical assistance for the exercise performances. The physiotherapists generally allowed this lay helping, but there were occasions where it was disapproved of. However, older people persisted in their activity as illustrated in the next extract.

Extract 6: Session 5: "Pauli" recruits assistance from "Aarre" to the obstacle course and proceeds to the activity regardless of the physiotherapists' disapproval, who is preoccupied with hands on assisting another client "Esteri". A peer "Laura" attends to the proceedings and provides verbal cues.

- 1 P: Would you hold (.) would you hold my hand if I do that? ((looks at Aarre and points at the track. Aarre looks at the track and walks over to Pauli, sits down next to him and starts a quiet conversation with him)) ...13 lines omitted where another client discusses her performance with the physiotherapist
- 2 PT: Wait (.) I'll come and walk you through = ((speaks to Pauli, who has already got up and is walking towards the track))
- 3 L: =Aarre (.) go and take Pauli by the hand ((shows Aarre how to take Pauli by the hand)).
- 4 PT: Good, you can then go and [have a rest.] ((speaks to Esteri as she walks her back to the chair))
- 5 L: [You make sure you hold on] properly so that ((speaks to Aarre))
- 6 E: I'm sure I can do this [().] ((speaks to physiotherapist))
- 7 PT: [Boys wait] a little (.) I'll have Maija sitting on that (1) would you
- 8 come here and sit down or would you prefer the chair over there? ((asks while leading Esteri by the hand))

In the above extract Pauli expressed his desire to walk through the obstacle course with an acknowledgement that he will need support by requesting assistance from his peer Aarre (line 1). They started a quiet discussion which was not caught by the microphone. Eventually Pauli got up and started walking with the aid of his cane towards the obstacle course. The physiotherapist was simultaneously involved in hands on assistance of another client Esteri, thus was unable to come to Pauli's assistance, but immediately disapproved of his attempt by asking him to wait (line 2). Pauli ignored her request and continued toward the obstacle course. Laura, a female peer, who was

sitting next to Aarre and watched the situation progressing, prompted (line 3) Aarre to provide the peer assistance. Aarre heeded to Laura's advice and proceeded to Pauli's assistance by grabbing his hand. Laura repeated her admonition (line 5) indicating her involvement in the situation, while the physiotherapist was still guiding another client Esteri. The physiotherapist repeated her request to halt the activity (line 7) when Pauli and Aarre were about to enter in the obstacle course. The physiotherapist addressed her talk to both of the clients by referring them as boys, which she had utilized several times during the class. The clients bypassed the request and started negotiating the obstacle course. The physiotherapist was still leading Esteri by hand back to her seat and thus, was unable to come to Pauli's assistance. In addition, she expressed (line 7) her next immediate task to assist Maija off from balance board, where she had been exercising alone for 3, 5 minutes.

Discussion

The aim of this study was to explore how older people construct their interaction in group exercise classes in geriatric rehabilitation. In particular, to study what was the scope of older people's agency during these situated interactions. Based on detailed analysis of interaction in encounters between the older people and the physiotherapists, four discourse categories were identified: taciturn exercising, submissive disagreeing, resilient endeavouring and lay helping. The findings reveal that the institutional context of group activity both restricts and enables the allowable scope of agency for older people by the physiotherapists.

In the data, older people's taciturn exercising was supported in praxis of the physiotherapists conducting geriatric rehabilitation in institutional context. The jointly constructed preferred flow of interaction was optimized for the task at hand, namely professionally lead group based physical activity. Similar features of clinical encounters, where the professionals controlled the discussions by asking questions and giving advices without inviting patients' views has previously been observed for other health care professionals, such as doctors and nurses (Collins, Drew, Watt, & Entwistle, 2005; Heath, 1992; Latimer, 1997; Peräkylä, 2002; Poskiparta,

Liimatainen, Kettunen, & Karhila, 2001). This pattern of interaction has been suggested to be effective for the functioning and achievement of clinical activities (Drew & Heritage, 1992). In group based exercises this taciturn exercising accomplishes the task at hand, provided that chosen exercises are well adapted to the group. Furthermore, patients' taciturn or silent behaviour have been found to have different dimensions varying from quietly assenting and demonstrating compliancy to feeling guilty and incompetent in health issues (Kettunen, Poskiparta, & Liimatainen, 2000; Kettunen, Poskiparta, Liimatainen, Sjögren, & Karhila, 2001). The findings in their study would imply that older people have accomplished different functions with their taciturn exercising. Further more, Bandura's (2001) notion of proxy agency, where people rely on powerful or skilful others to act at their behalf to attain the outcome they desire, can be used in situations where people do not have direct control over their social conditions and institutional practices, or when people believe others can do things better than themselves. Taciturn exercising resembles this proxy agency, since older adults relied on physiotherapists' expertise and proposed agenda. While this is a necessary condition in group based physical activities for older adults (Estabrooks, Munroe, Fox, Gyurcsik, Hill, Lyon et al., 2004), it can sometimes impede the development of personal competencies (Bandura, 2001).

Older people's displays of disagreement with the physiotherapist were simultaneously coupled with submission either by verbal or nonverbal actions. Patients' expressions of disagreement are infrequent (Heath, 1992), and can be treated as disruption of the normal institutional routine (Grainger, 1993; Wodak, 1997). Kettunen et al. (2000) found expressions of disagreement with patients during nurses' counselling sessions in hospital and concluded that patients were neither passive nor helpless, but all too frequently in their data the health care professional restricted patients' opportunities for participation. Their observations support the findings of this study, which illuminated the physiotherapists' position as one who maintains the institutional flow of activities predefined for the particular situation. In clinical situations where

there are genuine problems with understanding or performing exercises, this involuntary consenting to professional agenda is problematic. Difficulties experienced by heterogeneous older adults are bypassed when the physiotherapists orientate themselves to patients as a group. Mutual understanding and problem solving in collaboration can be enhanced utilising professional speech practices that allow patients to share their concerns and experiences (Kettunen, Poskiparta, & Karhila, 2003).

Older people's initiations and assertive behaviours found in resilient endeavouring and lay helping reveals that older people assumed an active role in physical activity, which according to Tulle (2007) demonstrates competency. Potentially this may cause conflict between individual choice and the institutional context of rehabilitation, where safety has been found to be the most important factor (Ballinger & Payne, 2002). This heightened professional responsibility of the safety contesting with clients' assertiveness was illuminated in the episodes where the physiotherapist denied a client's independent performance. In the first episode, the client demonstrated resiliency by re-negotiating the meaning of the physiotherapist's touch. He considered himself capable of performing the exercise independently, but the physiotherapist doubted his ability and provided hands on assistance. The client would not accept the assistance as a sign of lack of ability, but rather re-negotiated the touch being one of voluntary and social as a dance. This episode of the older adult assertive actions and maintenance his stance bears resemblance to Goffman's (1959) notion of re-negotiation of the situated meaning of performance. It was as if the older adult would not agree with the positioning he was granted by the physiotherapist, but rather contributed his own interpretation of the situated meaning (see (Davies & Harre, 1990).

In the second episode, this institutional emphasis on safe performance was produced jointly by older people and the physiotherapist. This provoked lay helping that occasionally resembled co-construction of group as a team (Goffman, 1959). Older people were both initiating and requesting support from peers. These occurrences resembled self-direction (Stewart &

Bhagwanjee, 1999; Viitanen & Piirainen, 2001) in older peoples' utilisation of their own and their peer's resources and not relying on the physiotherapist's skills. Furthermore, there appeared to be assumed ownership over the exercise programme in line with Stewart & Bhagwanjee's (1999) findings, with the sense of shared purpose and fellowship. Thus, older people were co-constructing exercise as meaningful and feasible activity, which they themselves were capable of mastering, which is in line with Tulle's (2007) findings of veteran athletes. This suggests that Jolanki's (2004) findings of active and healthy ageing being culturally preferred discourse may transfer to situated self-directed performances of activity.

These older people's physical and verbal actions demonstrating agency, however, create a challenge with common practises of geriatric rehabilitation. Whilst aiming to enhance older people's functional independence and community-dwelling, the situated practises seemed to restrict the opportunities for client initiations. Taciturn exercising with joint understanding and ability to perform appropriate physical tasks appears functional for the group based exercise context. Opportunities for discussions and joint problem solving are necessary, should difficulties in understanding and performance occur. However, this study shows that patients' disagreements and divergent views were not discussed. Rather, the group exercise context promoted physical activities, which was also acquired by the older adults. Their physical initiations, however, were neither approved nor discussed with the participants. Sustaining predefined flow of activities and glossing over patients' initiations, allowed the physiotherapist to maintain their own frame of reference and restricted the allowable scope of agency of older people.

The analysis concerns a small number of cases, thus there were insufficient data to examine whether these episodes of initiations and assertiveness are regularly associated with group exercise classes or in geriatric rehabilitation. However, the videotaped exercise sessions were ordinary physiotherapeutic group exercises in inpatient rehabilitation centers, and there were no special arrangements for the study. There could be some concern of atypical behaviour because the

participants were aware of being videotaped. However, participants quickly habituated to the camera and absorbed in the exercising, which have been supported in the literature (Jordan & Henderson, 1995). Finally, when interpreting these findings, one must remember that the data was collected in the context of Finnish culture and that all results may not apply cross-culturally.

Conclusions

This study shows delicate and challenging interaction between situated structural allowances and older people's agency in the geriatric rehabilitation context. On the one hand, default submission and taciturn positions contests with the object of geriatric rehabilitation in promoting autonomy and active participation. On the other hand, clients' independent actions challenge institutional mandates of safety and professional authority. This analysis provides a springboard for discussing older people's agency in health and social care. In order to develop professional practice, further research is needed to illuminate older people's construction of agency in institutional settings; what it may or should be and how the institutional context interact in its making. Older people's agency, whilst being likely to challenge institutional flow of activities, can be an integral part of the re-ablement process of rehabilitation. In order to promote clients agency during situated practises, the therapy context and exercises should be constructed in a manner that allows independent activities in group.

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Table 1

Transcript Notations of the Excerpts Presented in this Paper that were Translated by a Native British Translator, as Literally as possible from the Original Finnish Transcripts.

Symbol	Explanation
PT	Signifies therapist's talk
A, I, T etc. Initial of pseudonyms assigned for each client	Signifies client's talk
(2)	Timed pause within or between turns (in seconds)
(.)	Discernible pause too short to be timed
[]	Overlaps between utterances
=	Contiguous utterances or very rapid move from one utterance to another
<u>Text</u>	Word(s) emphasized
°text°	Word(s) spoken very softly or quietly
()	Unclear words or utterances, which cannot be heard
((text))	Clarificatory information about physical actions, gazes, laughter